STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
MARGARET M. O'NEILL BUILDING
410 FEDERAL STREET, SUITE 1
DOVER, DE 19901

VOICE: (302) 739-3620
TTY/TDD: (302) 739-3699
FAX: (302) 739-6704

January 25, 2016

The Honorable Jack Markell
Governor
Tatnall Building - 2nd Floor
William Penn Street
Dover, DE 19901

Dear Governor Markell:

The State Council for Persons with Disabilities (SCPD) has reviewed S.B. 142 which would expand Delaware's Public Assistance Code to provide preventative and urgent dental care to all eligible Medicaid recipients. Payments for preventative or urgent dental care treatments shall be subject to a $10.00 recipient copay and the total amount of dental care assistance provided to an eligible recipient shall not exceed $1,000.00 per year, except that an additional $1,500.00 may be authorized on an emergency basis for urgent dental care treatments through a review process established by the State Dental Director. In its November 19, 2015 FY17 budget presentation, the Department of Health and Social Services (DHSS) recommended the inclusion of 6-month funding [approximately 2.4 million (12/21/15 DMMA email)] to implement the adult dental benefit initiative. SCPD strongly endorses the proposed legislation and funding to implement the adult dental care program.

Research on dental health suggests that poor oral health is linked to increased risks for chronic health conditions such as heart disease and diabetes. Dental disease is not benign; it can be life-threatening. See attached article, "Dental problems - sometimes deadly - drive more people to ERs" (July 11, 2015). This problem is even more pronounced among individuals with disabilities because of their notoriously limited access to dental care. A survey conducted on the health status of individuals with disabilities in Delaware showed that almost a quarter (24.3%) of adults surveyed did not receive regular dental care. Adults who depend on state health insurance do not have dental care coverage through Medicaid.

While many of us have some anxiety, financial difficulty, or other challenge associated with our access to dental care, individuals with disabilities often face multiple difficulties.

Recent studies have shown that one's knowledge of dental care is a major predictor of dental health. Patients with cognitive disabilities are often dependent on others for assistance, whether for transportation, home care activities, decision-making about treatment, and/or payment. Physical disabilities can limit a patient's ability to practice effective dental hygiene and access adequate care in a dental office. While Delaware offers a good Medicaid program to meet the needs of children who qualify, virtually no financial assistance is available for adults with unmet dental needs.

In summary, the lack of state funding for adults with disabilities is a major impediment to dental care, and poor dental health is known to be a factor in a wide range of non-dental medical conditions.

S.B. 142 is designed as "enabling legislation". It would only be effective upon an appropriation. As noted previously, in its November 19, 2015 FY17 budget presentation, DHSS recommended the inclusion of 6-month funding (approximately 2.4 million) to implement the adult dental benefit initiative. SCPD strongly endorses such funding. It is consistent with a trend among the states to incrementally add an adult dental benefit to Medicaid state plans. See attached excerpt from National Academy for State Health Policy, "Adult Dental Benefits in Medicaid: Recent Experiences from Seven States" (July, 2015).

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our position or observations on the proposed legislation and associated funding.

Sincerely,

Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

cc: Delaware General Assembly
Ms. Drewry Fennell, Office of the Governor
Ms. Meredith Tweedie, Office of the Governor
Ms. Rita Landgraf, DHSS Cabinet Secretary
Mr. Brian Hartman, Esq., Disabilities Law Program
Developmental Disabilities Council
Governor's Advisory Council for Exceptional Citizens

P&L/SB 142 dental 1-25-16

USA TODAY — THE NEWS JOURNAL
SATURDAY, JULY 11, 2015

HEALTH

Dental problems — sometimes deadly — drive more people to ERs

Lack of insurance, access largely to blame

Laura Ungar
USA TODAY

JACK GRUBER, USA TODAY

University of Maryland School of Dentistry Urgent Care Clinic serves low-income patients referred from the ER, lacking dental insurance, or with emergency needs.

What started as a toothache from a lost filling became a raging infection that landed Christopher Smith in the emergency room, then in intensive care on a ventilator and feeding tube.

"It came on so quickly and violently, I was terrified," says Smith, 41, of Jeffersonville, Ind., who lacked dental insurance and hadn't been to a dentist for years before the problem arose last month. "I had no idea it could get this serious this quickly."

Smith is one of a growing number of patients seeking help in the ER for long-delayed dental care. An analysis of the most recent federal data by the American Dental Association shows dental ER visits doubled from 1.1 million in 2000 to 2.2 million in 2012, or one visit every 15 seconds. ADA officials, as well as dentists across the nation, say the problem persists despite health reform.

"This is something I deal with daily," says George Kushner, director of the oral and maxillofacial surgery program at the University of Louisville. "And there is not a week that goes by that we don't have someone hospitalized ... People still die from their teeth in the U.S."

Often, what drives people to the ER is pain, "like a cavity that hurts them so much they can't take it anymore," says Jeffrey Hackman, ER clinical operations director at Truman Medical Center-Hospital Hill in Kansas City, who's noticed a significant rise in the number of dental visits over the past five years.

Limited insurance coverage is a major culprit; all but 16% of dental ER visits are by the uninsured or people with government insurance. The Affordable Care Act requires health plans to cover dental services for children but not adults; federal officials say "essential" benefits were based on services included in employer-sponsored medical plans. Medicaid plans for adults vary by state and often cover only a short list of basic services. Medicare generally doesn't cover dental care at all.

By law, ERs have to see patients even if they can't pay. But although they often provide little more than painkillers and antibiotics to dental patients, they cost more than three times as much as a routine dental visit, averaging $749 a visit if the patient isn't hospitalized — and costing the U.S. health care system $1.6 billion a year.

"If we were going to the dentist more often, we could avoid a lot of this," says Ruchi Sahota, a California dentist and consumer adviser for the ADA. "Prevention is priceless."

ACCESS A CHALLENGE

But federal figures show four in 10 adults had no dental visit in the past year, and one big reason is cost. Just over a third of working-age adults, and 64% of seniors, lacked dental coverage of any kind in 2012, meaning they had to pay for everything out-of-pocket.

Meanwhile, the 10% of adults with Medicaid dental plans struggle to find dentists to take them; studies have shown that less than 20% of dentists accept Medicaid in some states, largely because reimbursements dip as low as 14% of private insurance reimbursement last year. Add to that a shortage of more than 7,000 dentists in the United States.

Americans who go without care pay a price. More than a quarter of working-age adults, and one in five seniors, have untreated cavities, and 19% of seniors have lost all their teeth. When poor people do get care, dentists say they usually get only basic services.

Besides lacking coverage, dentists say people tend to ignore dental problems until things get really bad, which can happen outside of business hours and send them to ERs.

Smith learned the hard way just how crucial oral health is.

The reggae vocalist and part-time security system installer says he'd been without dental insurance for a couple of years and hadn't been to a dentist for longer than that, when a filling fell out of a bottom left molar on June 6. He tried to fix it with a do-it-yourself kit, but the temporary filling came out during a concert that night. He tried to numb it with Anbesol the next day, but the pain got worse as his jaw swelled, and he drove to the emergency room at 4 a.m. the following morning.

Doctors there referred him to a nearby dentist, who saw the worsening infection and sent him back to the ER, where his tooth was removed. At home, the infection drained into his neck, making it difficult to breathe — prompting a third trip to the ER. As he sat in the waiting room, the swelling doubled. "I could feel my windpipe close," he recalls.

Doctors admitted him, cut into his neck to insert a drain for the infection and gave him strong antibiotics — and kept him in the hospital for a week. A day after returning home, all he felt up to doing was resting with his dachshund, Sinatra. The scar in his neck was visible, and his still-swollen jaw made it impossible to open his mouth all the way.

TOWARD SOLUTIONS

Dentists say patients can be much better served by getting regular care in the community, where many issues that bring people to ERs can be handled and serious problems prevented. Community health centers with dental clinics offer one long-standing alternative for low-cost care, and another newly touted option involves university dental school clinics.

The University of Maryland School of Dentistry, for example, has a pre-doctoral clinic, where students provide a range care under the close supervision of faculty, and a walk-in clinic for people with urgent needs.

An ADA report last year found that dental ER visits had fallen between 2012 and 2014 in Maryland amid state reforms such as increased Medicaid reimbursement for dentists and a larger provider network — inspired in part by the 2007 death of a 12-year-old boy from a brain infection that began as a toothache.

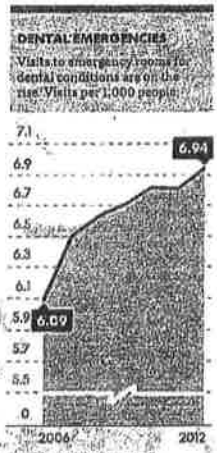
The ADA also points to ER referral programs across the nation to get patients into dental-school treatment.

Officials say there currently are 125 such programs, up from eight a year ago. In Kansas City, patients at Truman have only to walk across the street when they're referred to the University of Missouri clinic.

Smith says ER staff helped him sign up for Indiana Medicaid, and now that he's been referred to a dentist who has agreed to take him, he plans to get regular checkups and take meticulous care of his teeth at home.

Michael McCunniff, chairman of the University of Missouri-Kansas City Department of Public Health and Behavioral Science, says that's a much better plan — for all Americans — than forgoing care and frantically seeking help in the ER.

"All that does is put a Band-Aid on the problem," he says. "It doesn't cure it."



Sources 2015 American Dental Association analysis of 2006-2012 Nationwide Emergency Department Sample data, 2006-2012 Medical Expenditure Panel Survey data, and 2006-2012 U.S. Census data

FRANK POMPA, USA TODAY

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

July 2015

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

Adult Dental Benefits in Medicaid: Recent Experiences from Seven States

Andrew Snyder and Keerti Kanchinadam

The National Academy for State Health Policy (NASHP) conducted interviews with state administrative and legislative branch officials as well as dental stakeholders in California, Colorado, Illinois, Iowa, Massachusetts, Virginia, and Washington, all of which have recently taken action to add, reinstate, or enhance their Medicaid adult dental benefit.

This brief summarizes policy lessons and themes about why states decided to take up this coverage option and how they are implementing it. Accompanying case studies provide a more in-depth look at each state's adult dental benefit.

Key Findings

- There is growing recognition of the importance of oral health as it relates to overall health—including pregnancy, avoidable emergency room utilization, and chronic conditions such as diabetes and heart disease—as well as employability. These data points, as well as personal experiences with individuals who cannot access routine dental care, resonated with key state decision-makers.

- Policymakers generally support providing adult dental benefits to Medicaid enrollees, but prioritizing spending on the benefit can be challenging, given the need of states to balance limited resources with many competing priorities.

- Engagement by high-level state policymakers, including legislative leaders, governors' staff, and Medicaid agency leadership, along with active legislative outreach by dental associations and oral health coalitions is important to raise the profile of the issue.

- In many states, enhancements are progressing incrementally. In some states the benefit is being extended only to certain groups of enrollees such as pregnant women or the Medicaid expansion population. In other states the benefit is capped with a dollar limit.

- Many states expanding their adult dental benefit have done so by building on improvements made to their children's dental coverage programs over the last decade. This includes leveraging existing contractual relationships, provider networks, and care coordination efforts.

- States' decisions on adult dental coverage were affected by their broader work on implementing health reform. Enhanced federal funding through the Affordable Care Act's (ACA) Medicaid expansion motivated action in several states. Some states are also beginning to consider how dental services may fit into payment and delivery system reform efforts such as the State Innovation Models Initiative.

Introduction

Oral health is an important but often neglected part of overall health, particularly for adults. For children, states are required to cover dental services in Medicaid and the Children's Health Insurance Program (CHIP), also the ACA extended dental benefits to more children through health insurance exchanges and Medicaid expansion. While implementation issues remain, Medicaid-enrolled children have seen significant gains in access to dental coverage and care over the last 10 years.[1] In contrast, adult dental coverage is an optional benefit in Medicaid and the ACA does not address dental benefits for adults. As a result, Medicaid adult dental benefits vary significantly across states. In 2015, only 15 offered extensive adult dental benefits, 17 states offered a more limited package, 15 states offered emergency-only dental benefits, and 4 states offered no adult dental benefit.[2]

Poor and near-poor adults ages 35-44 are more than twice as likely to experience gum disease and untreated tooth decay than non-poor adults, and almost twice as likely to have lost a tooth due to those conditions.

A 2012 survey found that 91 percent of adults aged 20-64 had dental caries and 27 percent had untreated tooth decay.[3] Poor and near-poor adults ages 35-44 are more than twice as likely to experience gum disease and untreated tooth decay than non-poor adults, and almost twice as likely to have lost a tooth due to those conditions. Poor seniors are more than twice as likely to have lost all of their natural teeth than non-poor seniors.[4]

Historically, states have cut back Medicaid adult dental benefits due to state fiscal challenges, including in the wake of the 2007-2009 recession. In the past two years, however, a number of states have decided to enhance the dental benefits provided to adult Medicaid enrollees.

NASHP examined recent experiences in seven states that acted to add, reinstate, or introduce adult dental benefits in the last two years: California, Colorado, Illinois, Iowa, Massachusetts, Virginia, and Washington. These states took a range of approaches to adult dental benefits in regard to benefits, program administration, and the legislative or administrative vehicles for advancing the policy change. Across these states, however, some common themes emerged around:

- Key policymakers and advocates who were engaged in the decision, and the key data points that were important in making the case;
- States' adoption of incremental improvements in order to balance dental benefits with other competing budgetary priorities;

Case Studies

For more on the actions taken on Adult Dental Benefits in the states listed in Table 1, see the Case Studies starting on page 13.

- Application of lessons learned from improvements to states' pediatric dental benefits to adult populations; and
- Desire among states to explore how dental benefits might fit within their broader work on payment and delivery system reform in future.

These findings were informed by interviews with a range of experts in each state including state officials—Medicaid leaders, legislators, and governors' health policy advisors—and state dental associations, oral health coalitions, and other key stakeholders conducted between February and May 2015. This brief summarizes the high-level themes that emerged from our interviews. More detailed descriptions of the approaches taken in each of the seven states are provided in case studies in Appendix II. Below is a chart that summarizes the actions taken in each of the seven states, the legislative or administrative vehicle used, date of implementation, and the benefits offered.

Table 1. Actions Taken on Adult Dental Benefits in Seven States

State	Legislative or Administrative Vehicle	Date Implemented	Benefits and Populations Covered
California	State budget, AB 82 (2013)	May 2014	Reinstated most benefits for all Medicaid-enrolled adults, with $1,800 annual "soft cap" that can be exceeded when medical necessity is proven. Additional services covered for pregnant women.
Colorado	SB 242 (2013)	April 2014	Introduced benefits for all Medicaid-enrolled adults, with $1,000 annual cap. Dentures are exempt from the cap.
Illinois	State budget, SB 741 (2014)	July 2014	Reinstated benefits for all Medicaid-enrolled adults. Additional preventive services covered for pregnant women. (Gov. Rauner's proposed FY2015 budget would cut the rates paid for adult dental services.)
Iowa	Section 1115 Medicaid waiver	May 2014	Introduced "earned benefit" to Medicaid expansion population; individuals who establish a regular source of care qualify for more expansive benefits.
Massachusetts	Annual state budgets	January 2013 March 2014 May 2015	Reinstated services for all adults incrementally – first fillings for front teeth, then all fillings, then dentures. Additional services covered for persons determined eligible through the Department of Developmental Services.
Virginia	Governor's Healthy Virginia plan (2014)	March 2015	Introduced dental benefit for adult pregnant women over age 21.
Washington	FY 2013-2015 biennial operating budget	January 2014	Reinstated extensive benefits for all Medicaid-enrolled adults.

Key Themes Among States

Partnerships and Gathering Support

Leadership

Involvement by legislative and administrative branch champions was critical in each state that NASHP interviewed. The champions in several states were people with particularly high authority—including Frank Chopp, Washington State Speaker of the House, Darrell Steinberg, California Senate President pro tempore, and Virginia Gov. Terry McAuliffe. Interviewees noted that the addition of adult dental benefits did not usually face organized opposition, but the involvement of high-level champions was important to make and keep adult dental benefits a priority in the midst of many other state concerns.

Oral health coalition members, stakeholders, and provider groups across states focused primarily on the message that oral health is part of overall health—and that there are linkages between oral health and health conditions such as diabetes, heart disease, and potentially, adverse birth outcomes.[5] Data on use of hospital emergency departments (EDs) for preventable dental conditions, and increases in such visits in states following elimination of adult dental benefits was also noted as important. However, interviewees identified that it was particularly compelling for policymakers to personally meet individuals experiencing pain and tooth loss from untreated dental conditions. Attendance at dental association sponsored events in California and Virginia, where free dental care was provided to underserved communities, was noted as a key factor in policymakers' engagement in the issue.

Relationship building

In all states, efforts to advocate for, implement, and operationalize a new benefit program required the collaboration of many different partners. The most frequently cited partners were oral health stakeholder groups such as state dental associations, dental hygiene associations, oral health coalitions, and oral health-focused philanthropies. The ability of these groups to lobby legislators was noted as an important factor in several states. Oral health stakeholders noted the importance of engaging a broader group of voices from outside of the dental community, like community health centers, anti-poverty groups, and advocates for seniors and individuals with disabilities.

In most states, strong partnership with the state's dental association was an important factor. Several state dental associations indicated that they decided to advocate for the addition of

benefits, even if the policy didn't fully address the concerns of their membership with program administration and provider reimbursement rates, as a way to demonstrate their support for improving oral health and access to care for Medicaid-enrolled individuals.

Good relations between dental associations, oral health coalitions, and Medicaid agencies within a state helped keep dental benefits in front of key decision-makers, so that action could be taken on adult benefits when a window of opportunity opened. All states NASHP spoke with said that the new benefit came about as a result of years of effort and taking advantage of a ripe opportunity, for example opportunities presented by enhanced federal funding for Medicaid expansion under the ACA.

Approach and Implementation

Financing strategies

Most states financed their adult dental benefit through state general funds, and the benefit was often introduced in the context of a state's biennial budget process. One exception was Colorado, which redirected a portion of a trust fund that funded the state's high-risk pool, made obsolete through the ACA, to serve as the state share of funding for its new adult dental benefit.

Interviewees across all seven states shared that an adult dental benefit, particularly one limited to certain services or populations, is a relatively minor budget item in the context of state Medicaid budgets. In 2013, the National Health Expenditure Accounts estimated that total state and local spending on dental services for children and adults in Medicaid was about $3.2 billion, equaling less than two percent of total state and local spending on Medicaid.[6] Washington's restoration of a dental benefit for 874,000 Medicaid-enrolled adults required $23 million in state funding; Virginia's benefit for 45,000 pregnant women is projected to cost approximately $3 million in the first two years.

Officials in several states reported that the ACA presented a unique opportunity to expand dental coverage to many new enrollees at a reduced cost to the state. In particular, states that opted to expand Medicaid eligibility to individuals up to 133 percent were able to leverage the 100 percent federal match made available through the ACA to help mitigate the cost of a new adult dental benefit. The availability of new federal funding through Medicaid expansion was particularly important in Washington's consideration of an adult benefit. Although the state could have opted to only cover dental services for the expansion population, state officials felt it was important to offer coverage to all adults to ensure continuity and equity of coverage for all enrollees.[7]

Research on links between improvements in oral health and potential reductions in overall health care spending, while compelling to state officials, generally didn't factor into states' budgeting for adult dental benefits. Interviewees in several states noted that demonstrating and booking short-term cost savings is challenging for states that are tied to short annual or biennial budgets and often lack proper systems to coordinate savings that cross medical and dental spheres—for example, reductions in ED usage from improved access to routine dental care. However there was general support for the idea that dental coverage could save money in the long-term, particularly as states move towards efforts to integrate dental and medical services within larger payment and delivery system reforms.

All seven states voiced concern about the perpetual vulnerability of the benefit; because it is categorized as "optional," it can be cut or scaled back during times of fiscal stress. Most states felt confident that the benefits they introduced are going to be fiscally sustainable for the foreseeable future, though Illinois is already considering a potential cutback in adult benefits as part of its 2015 budget negotiations.

Incremental Approaches

Most interviewees expressed a desire to extend full dental benefits to all adults in Medicaid, allowing enrollees to obtain medically necessary care for tooth decay and gum disease. However, many

states pursued an incremental expansion of benefits—by limiting the benefit to certain populations, specific covered services, or placing a dollar limit on the benefit package. For example, Virginia extended comprehensive dental benefits only to women enrolled in Medicaid during pregnancy and 60 days postpartum; non-pregnant adults in Medicaid are covered only for emergency dental services. Over the last three years Massachusetts has gradually added services including fillings, initially for front teeth only, later for all teeth, and dentures back into its adult benefit package. In Colorado, the new dental benefit is comprehensive and available to all adults enrolled in Medicaid, however the benefit is capped at $1,000 per enrollee per year. Dentures are exempt from the benefit cap.

In most cases, the state chose an incremental expansion because of fiscal concerns. There was wide acknowledgement among interviewees that an incremental benefit is better than no benefit, and there was also a desire among states to limit benefits within what their budget would bear, to reduce the possibility of future cutbacks. Multiple interviewees noted that a "pendulum swing" of repeated expansions and contractions had created challenges and confusion for enrollees, providers, and Medicaid agencies alike. During periods of reduced benefits, enrollees frequently forego care due to inability to pay. Providers—both dentists and safety net providers like community health centers—reported feeling strain from multiple changes to states' benefit packages, in regard to their ability to develop treatment plans for Medicaid-enrolled patients who may no longer have coverage for necessary services. State officials must manage the administrative challenge of stopping and restarting benefits, and face pent-up demand when benefits are restored—particularly for expensive services like dentures, which might have been avoided with routine dental care.

Building on Existing Programs

States across the country have made great progress in improving Medicaid-enrolled children's access to dental care over the last decade.[8]

Several states built on these successes in the policies they adopted for their adult dental Medicaid benefit. In particular, states focused on administrative simplification, including the use of specialized dental administrative vendors, and development of supports to help connect enrollees to dental care.

- **Iowa's** unique Dental Wellness Plan incorporates a tiered "earned" benefit approach for the newly eligible Medicaid expansion population that conditions certain benefits on patients establishing a relationship with a dentist whom they see regularly. To help ensure that adults can build those relationships, Iowa is building on the network of Title V-funded county-based dental care coordinators that it has built over the last 10 years through its I-Smile children's dental program. Iowa also used the tiered structure to increase the capitation rate for the Dental Wellness Plan, enabling it to address some longstanding concerns about provider reimbursement rates.

- **Virginia** used its successful Smiles for Children program as the basis for its benefit for pregnant women. Smiles for Children has built up strong dentist participation since its introduction in 2005 due to simpler administration and higher reimbursement rates.
- **Colorado** used its CHIP benefit—which uses

a specialized dental vendor—as a model for its transition to a new Administrative Services Organization (ASO).

Other states NASHP interviewed reinstated the same benefits, administrative processes, and reimbursement rates that had been cut in previous years. Many of these states saw that as a first step, and expressed a desire to continue improving program administration and provider participation in future years.

Officials in several states reported that the ACA presented a unique opportunity to expand dental coverage to many new enrollees at a reduced cost to the state.

Outreach and Education

States indicated that outreach and education to both newly eligible enrollees and providers will be crucial to the ongoing success of the new benefit including ensuring that enrollees connect to regular and ongoing care. In addition to initiatives like Iowa's use of dental care coordinators, states are also working in partnership with stakeholders in the dental and medical communities to ensure that outreach and education efforts are successful. In Virginia, the state has partnered with OBGYNs and pediatricians to help communicate the availability of dental benefits for pregnant women, and to spread information to patients and providers that receiving dental care during pregnancy is safe and appropriate. Colorado is working closely with its state dental association to recruit dentists to serve Medicaid-enrolled clients. Despite progress, provider recruitment and network adequacy remain a concern in many states.

Evaluating Success

NASHP spoke with state officials and stakeholders about how they would gauge whether they had achieved their policy goals from introduction or reinstatement of adult dental benefits. States are primarily looking to traditional measures to gauge their success, including utilization rates among enrollees, provider participation rates, and calls to customer service hotlines from enrollees seeking care.

NASHP spoke to many of these states very soon after their adult dental benefits were implemented, so few were able to provide detailed findings. Some states, however, are reporting early successes in improving access to care and provider engagement.

- **In Iowa**, Delta Dental (the administrator of the Dental Wellness Program) reported that, as of February 2015, 36,500 of the program's 115,000 enrollees had received a dental service since the program began in May 2014.[9]
- **In Washington** State, more than 204,000 Medicaid-enrolled adults received a dental service in CY 2014, an increase from the roughly 136,000 adults who received services in CY 2010—the year before services were cut back. Howev-

er, this happened in the context of a doubling of the number of enrollees (from 410,000 to 874,000) due to Medicaid expansion, so the rate at which enrollees used services fell from 33 percent to 23 percent.[10]

- **Colorado** reported some success from their provider recruitment efforts, conducted in collaboration with the Colorado Dental Association (CDA). The CDA reported that the number of Medicaid-participating dentists had grown 17 percent between 2012 and 2014.[11]

Additionally, several states are setting concrete expectations around linkages between dental benefits and overall health spending. Colorado has set yearly performance standards for its administrative services contractor. In year two, the state is focusing on decreased utilization of the emergency room for non-emergency dental care. In Iowa, because the Dental Wellness Plan is being implemented through a section 1115 demonstration waiver, the state, in partnership with the University of Iowa Public Policy Center, has developed a detailed evaluation plan that will attempt to track whether enrollment in the Dental Wellness Plan results in reduced ED utilization, and also measure whether enrollees receiving dental services experience better outcomes related to chronic conditions like diabetes.[12]

Looking Forward

Officials and advocates in many states saw the addition or restoration of adult dental benefits as the first step in addressing oral health for Medicaid-enrolled adults, with more action being necessary to ensure that enrollees can effectively access care. In Colorado, the state legislature has followed up the initial introduction of a dental benefit with subsequent action to provide coverage for dentures (outside of the $1,000 annual cap) and to provide reimbursement rate increases for targeted services. State officials in Iowa are considering how the Dental Wellness Plan might fit into the state's shift toward managed care for all Medicaid-enrolled populations. In Washington, oral health stakeholders are working to partner with the Washington Health Care Authority to research the possibility of developing a targeted, enhanced benefit for pregnant women and people with diabetes, modeled after the state's successful Access to Baby and Child Dentistry program. Other states like Illinois, however, are already facing the possibility of cutbacks to benefits in the context of a changing state budget picture.

States are also looking for ways to expand their ability to provide dental services beyond the traditional dental office. California recently enacted legislation to permit Medicaid reimbursement to dentists who provide dental care via telehealth.[13] This supports programs such as the Virtual Dental Home, a model where dental hygienists and assistants provide preventive and limited restorative services in community settings like nursing homes, schools, and Head Start sites, with connection via telehealth to a supervising dentist. Colorado will soon begin a pilot project to replicate the Virtual Dental Home model, funded by the Caring for Colorado Foundation.[14]

Lastly, officials and advocates in several states are looking closely at ways to weave oral health into broader payment and delivery system reforms, to reflect oral health's connection to overall health. Stakeholders from the Virginia Oral Health Coalition will be leading a workgroup through Virginia's State Innovation Model (SIM) design planning process. They will make recommendations on strategies that Accountable Communities for Health (ACH), regional multi-sector collaboratives that make decisions about allocation of health care resources, can use to address the oral health of their communities. In Washington, although oral health was not addressed in detail in the state's SIM Innovation Plan, state officials indicated that they expected several ACHs to identify oral health as a priority area for improvement. Colorado is considering ways to facilitate collaboration between its dental ASO and its Regional Care Coordination Organizations (the state's Medicaid-focused accountable care entities). Colorado is also examining ways to develop better linkages between dental claims data and its all-payer claims database.

Conclusion

Adult dental coverage's status as an optional Medicaid benefit means that it is an area where states have some latitude to make cutbacks, so benefits tend to contract during difficult budget circumstances—such as the 2007-2009 recession—and expand as fiscal pressures ease. States that NASHP examined took a variety of approaches to adding, reinstating, or introducing adult dental benefits, but they have attempted to do so in a way that is fiscally sustainable, and also provides meaningful access for program enrollees. Many have also built on lessons learned from improvements to their Medicaid dental programs for children.

The idea of providing adult dental benefits to Medicaid enrollees is generally supported by policymakers—who frequently cited the importance of oral health, high levels of unmet need among low-income populations, and links between oral health and overall health. However, prioritizing spending on the benefit can be challenging, given states' need to balance limited resources and many competing priorities. Important factors in these seven states included funding opportunities through the ACA, personal engagement by high-level state policymakers, and strong partnerships with dental associations and oral health coalitions to raise the profile of the issue and assist in implementation of the benefit.

These seven states' experiences may be instructive for other states considering addressing adult dental coverage. The case studies in Appendix II of this brief provide much more detail on the strategies that each state pursued.

Endnotes

1. Andrew Snyder, Keerti Kanchinadam, et. al. Improving Integration of Dental Health Benefits in Health Insurance Marketplaces (Washington, DC: National Academy for State Health Policy, 2014).

2. The American Dental Association classifies Medicaid adult dental benefits into the following categories: Extensive benefits: A comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the American Dental Association (ADA); per-person annual expenditure cap is at least $1,000. Limited: Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the ADA; per-person annual expenditure for care is $1,000 or less. Emergency Only: Relief of pain under defined emergency situations. (Center for Health Care Strategies, "Medicaid Adult Dental Benefits: An Overview." Retrieved May 21, 2015. http://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_21915.pdf.)

3. Bruce Dye, et. al. Dental Caries and Tooth Loss in Adults in the United States, 2011-2012. NHCS Data Brief no. 197 (Hyattsville, MD: National Center for Health Statistics, May 2015).

4. Bruce Dye and Gina Thornton-Evans, "Trends in oral health by poverty status as measured by Healthy People 2010 objectives," Public Health Reports 125: no. 6, 817-830 (May-June 2010). Poor is defined as income less than or equal to 100 percent of the Federal Poverty Level (FPL). Near-poor is defined as income between 100 and 199 percent FPL, and non-poor as income greater than or equal to 200 percent FPL.

5. Andrew Snyder, Oral Health And The Triple Aim: Evidence And Strategies To Improve Care And Reduce Costs (Washington, DC: National Academy for State Health Policy, 2015).

6. Centers for Medicare and Medicaid Services, "National Health Expenditures by type of service and source of funds, CY 1960-2013." Retrieved May 26, 2015. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

7. Interview with MaryAnne Lindeblad, Nathan Johnson, and Gail Krieger, Washington Health Care Authority, April 8, 2015.

8. Centers for Medicare and Medicaid Services, CMS Oral Health Initiative and Other Dental-Related Items (Baltimore, MD: U.S. Department of Health and Human Services, April 2013), CIB-04-18-13.

9. Interview with Beth Jones and Gretchen Hageman, Delta Dental of Iowa, February 25, 2015.

10. Personal communication with Nathan Johnson, Chief Policy Officer, Washington State Health Care Authority, April 8, 2015.
11. Interview with Colorado Dental Association, March 26, 2015.
12. Iowa Medicaid Enterprise and University of Iowa Public Policy Center, "Iowa Dental Wellness Plan Evaluation." (September 2014). Retrieved May 26, 2015. http://dhs.iowa.gov/sites/default/files/DentalWellnessPlanEvaluationDesign_Sept2014.pdf.
13. California Assembly Bill 1174. Approved by Governor September 27, 2014.
14. Caring for Colorado Foundation, "Caring for Colorado Announces New, Major Investments," news release, January 26, 2015, http://www.caringforcolorado.org/post/newsroom/caring-colorado-announces-new-major-investments.

About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP pro- vides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

Acknowledgments:

The authors are grateful to the dozens of state officials, experts, and stakeholders who generously shared their time and expertise with us. A list of interviewees is provided in an appendix to this brief. Any errors or omissions are the authors'. The authors would also like to thank our NASHP colleagues Alice Weiss, Sarabeth Zemel, Jackie LeGrand, Christina Miller, Jennifer Laudano, Melanie Feliciano, and Trish Riley for their assistance in reviewing and preparing the brief. Special thanks to Najeia Mention for her invaluable assistance in managing project interviews and site visits.

This brief was made possible through the support of the DentaQuest Foundation.

Appendix I: Interviewee List

CALIFORNIA
Bob Isman
Former Dental Program Consultant
California Department of Health Care Services

Jenny Kattlove
Senior Director of Programs
The Children's Partnership

René Mollow
Deputy Director, Health Care Benefits and Eligibility
California Department of Health Care Services

Nik Ratliff
Section Chief, Contract Management and Administration
California Department of Health Care Services

Nicette Short
Director of Public Policy
California Dental Association

Darrell Steinberg
Shareholder
Greenberg Traurig, LLP
Former Senate President pro Tempore, California State Senate

Chris Wordlaw
Section Chief, Provider and Beneficiary Services
California Department of Health Care Services

COLORADO
Alyssa Aberle
President
Colorado Dental Hygienist Association

Deborah Foote
Executive Director
Oral Health Colorado

Bill Heller
Provider Relations and Dental Program Division Director
Department of Health Care Policy & Financing

Greg Hill
Executive Director
Colorado Dental Association

Jeff Kahl
Co-Chair of Council on Governmental Relations
Colorado Dental Association

Brett Kessler
President
Colorado Dental Association

Jennifer Miles
President, Miles Consulting, Inc.

Carol Morrow
Second Vice President and Secretary
Colorado Dental Association

Jeanne Nicholson
Former Senator
Colorado Senate

IOWA
Lawrence Carl
Executive Director
Iowa Dental Association

Peter Damiano
Director, Public Policy Center
Professor, Preventive and Community Dentistry, University of Iowa

Sabrina Johnson
Policy Specialist
Iowa Medicaid Enterprise

Beth Jones
Public Benefit Manager
Delta Dental of Iowa

Gretchen Hageman
Dental Wellness Plan Director
Delta Dental of Iowa

Sally Nadolsky
EPSDT Manager
Iowa Medicaid Enterprise

Bob Russell
Public Health Dental Director
Iowa Department of Public Health

Robert Schlueter
Bureau Chief of Adult & Children's Medical Programs
Iowa Medicaid Enterprise

Andria Selp
Affordable Care Act Project Manager
Iowa Medicaid Enterprise

Jennifer Vermeer
Assistant Vice President for Health Policy and Population Health
University of Iowa Health Care

ILLINOIS
Mona Van Kanegan
Co-founder and Co-director of Oral Health Forum
Heartland Alliance

Dave Marsh
Director of Government Relations
Illinois State Dental Society

Gina Swehla
Acting Bureau Chief
Illinois Department of Healthcare and Family Services

MASSACHUSETTS
Patricia Edraos
Health Resources/Policy Director
Mass League of Community Health Centers

Stacia Castro
Specialty Provider Network Manager
MassHealth

Ellen Factor
Director of Dental Practice
Massachusetts Dental Society

Brian Rosman
Research Director
Health Care for All

John Scibak
Representative
Massachusetts House of Representatives

Shannon Wells
Oral Health Affairs Manager
Mass League of Community Health Centers

Jane Willen
Dental Program Manager
MassHealth

VIRGINIA
Terry Dickinson
Executive Director
Virginia Dental Association

Pat Finnerty
President, Board of Directors, Virginia Dental Association Foundation
Senior Advisor, DentaQuest Foundation

Joseph Flores
Deputy Secretary of Health and Human Resources
Office of the Secretary of Health and Human Resources

Sarah Holland
Executive Director
Virginia Oral Health Coalition

Anna Healy James
Policy Director
Office of Governor McAuliffe

Cheryl Roberts
Deputy Director of Programs
Department of Medical Assistance Services

Myra Shook
Dental Program Manager
Department of Medical Assistance Services

Bryan Tomlinson
Division Director of Health Care Services
Department of Medical Assistance Services

WASHINGTON
Sarah Vander Beek
Chief Dental Officer
Neighborcare Health

Walt Bowen
President
Washington State Senior Citizens' Lobby

Eileen Cody
Representative
Washington State House of Representatives

Robert Crittenden
Senior Health Policy Advisor
Office of Governor Inslee

Colleen Gaylord
Chair, Regulation & Practice Committee
Washington State Dental Hygienist Association

Bracken Killpack
Executive Director
Washington State Dental Association

Tony Lee
Senior Fellow
Solid Ground

Nathan Johnson
Chief Policy Officer
Washington State Health Care Authority

Gail Krieger
Section Manager
Washington State Health Care Authority

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority

Kelly Richburg
Policy Advocate/Analyst
Washington Dental Service Foundation

Laura Smith
President and CEO
Washington Dental Service Foundation